WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

OFFICE OF BEHAVIORAL AND ALTERNATIVE HEALTH CARE

ICF/IID ADMITTANCE / DISCHARGE / TRANSFER TRACKING INFORMATION

MEMBER'S NAME_____ D.O.B._____

MEDICAID NUMBER _____SSN_____

CURRENT ADDRESS_____

_____COUNTY_____

CASE MANAGER _____

DATE OF ADMITTANCE / DISCHARGE / TRANSFER **(please circle)** _____

NEW ADDRESS _____

_____COUNTY_____

NEW PROVIDER AGENCY _____

TELEPHONE NUMBER _____

NEW CASE MANAGER _____

REASON FOR TRANSFER / DISCHARGE _____

_____ _____

Signature of Person Completing Form Title

_____ _____

Printed Name Printed Title

Date Completed: _____

INSTRUCTIONS FOR DISCHARGE/TRANSFER: THIS FORM IS TO BE COMPLETED BY THE PROVIDER WHICH DISCHARGES OR TRANSFERS THE INDIVIDUAL. IT MUST BE SUBMITTED TO THE BUREAU FOR MEDICAL SERVICES' CONTRACTED AGENT, PC&A, 202 GLASS DRIVE – CROSS LANES, WEST VIRGINIA 25313, PHONE NUMBER 304-776-7230. FAX NUMBER 304-776 -7247 WITHIN 7 DAYS OF DISCHARGE/TRANSFER

B&AHC-ICF/IID DD-7

REVISED May 2014